Synergy REALITY

D.C. Don't Stand for Dodge City

Violence is considered a public health problem because it is a major cause of injury and death in the United States. Homicide has become the tenth leading cause of death in the U.S. and the sixth leading cause of years of potential life lost. Among young people (ages 15-24) homicide is the second leading cause of death. The homicide rate among young males in the U.S. is approximately 20 times higher than homicide rates in most other industrialized nations.[1] A recent national study indicates that 1 in 13 teens carry a gun to school and that teens who carry guns are more likely to be users of cocaine or other drugs.

Homicide data represents only a small aspect of interpersonal violence. Some surveys have demonstrated that assault rates can be 100 times greater than homicide rates and that assault rates for urban minority neighborhoods can be more than twice the total assault rate.[2]

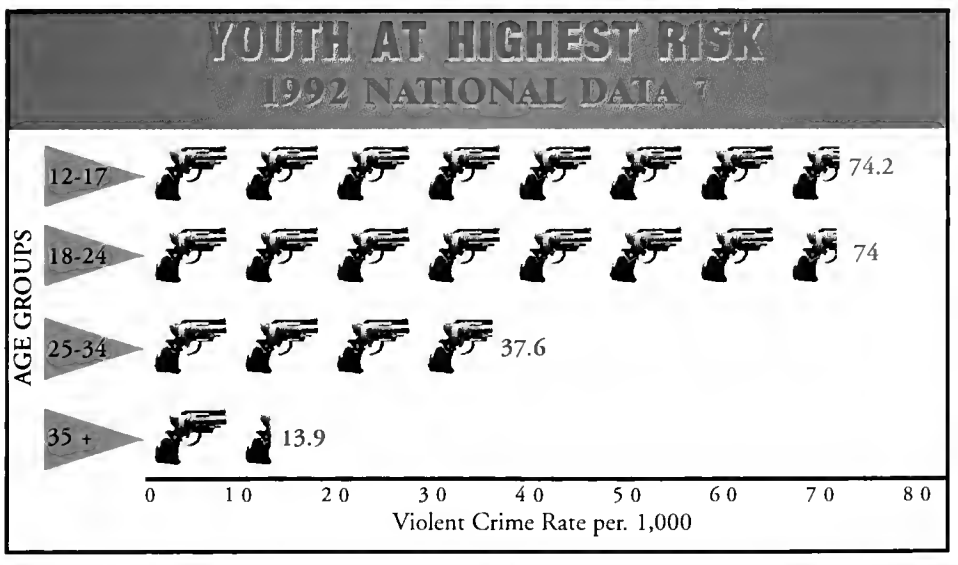
District Youth at Risk for Violence

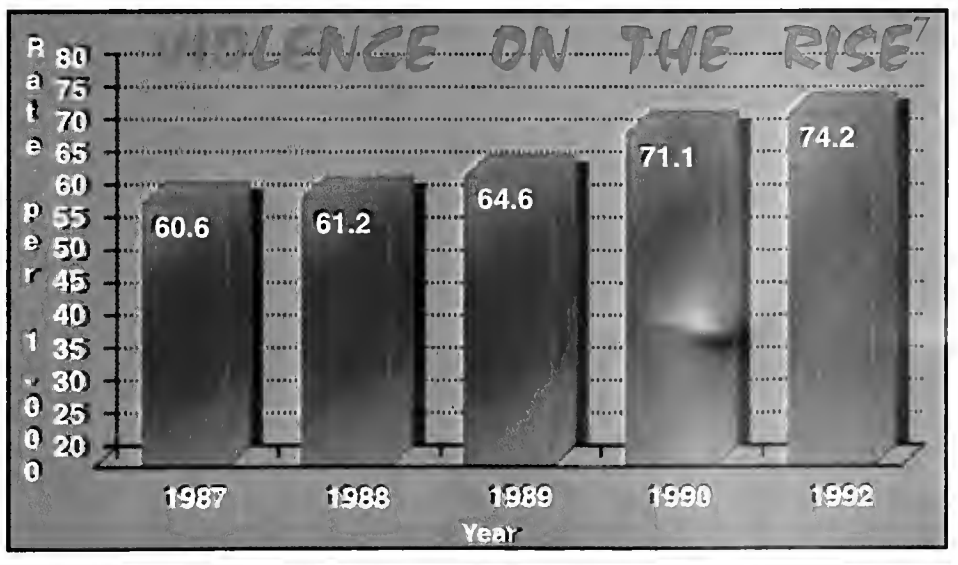
Studies have shown the risk of interpersonal violence is strongly correlated to low socioeconomic status and unemployment.[3] The following data indicate that several negative socioeconomic factors impact many adolescents living in the District. This exposure may increase an adolescent's risk for interpersonal violence. The data appears to indicate that African American adolescent males living in areas with low socioeconomic indicators are particularly at risk.

- 80% of the District's poor are African American. Twenty percent of youth and young adults who live in the District are poor.
- Between 1981-1989, the District's homicide death rate was six times higher than the national average (In 1990, the homicide rate for D.C. was 66.7 per 100,000 population.)
- Between 1981-1990, 50.8% of all adolescent and young adult (ages 15-24) deaths were attributable to homicide.
- In 1991, fifty percent (50%) of the total number of homicide victims were adolescents or young adults, and 63% of all alleged homicide assailants were age 24 and under.
- DC experienced a 520 percent increase in juvenile arrests for homicide over the eighth year period between 1982 and 1990.
- Males constituted 86 percent of total juvenile arrests in 1991, and youth ages 15 to 16 comprised 43% of the arrested juvenile population.
- Juveniles ages 15 to 16 comprised the largest proportion arrested on drug charges (52%), and juveniles age 17 were the second largest proportion at 34%. Approximately 19% of all juveniles arrested on drug charges tested positive for drug use.
- The total unemployment rate for the District in 1991 was 7.7% compared to the national rate of 6.7%. Youth ages 16-19 who were actively looking for work experienced an unemployment rate of 17.8%. In some wards of the city the unemployment rate was 2 to 4 percentage points higher than the national rate.
- In 1993, 90% of adolescent homicide victims were shot.

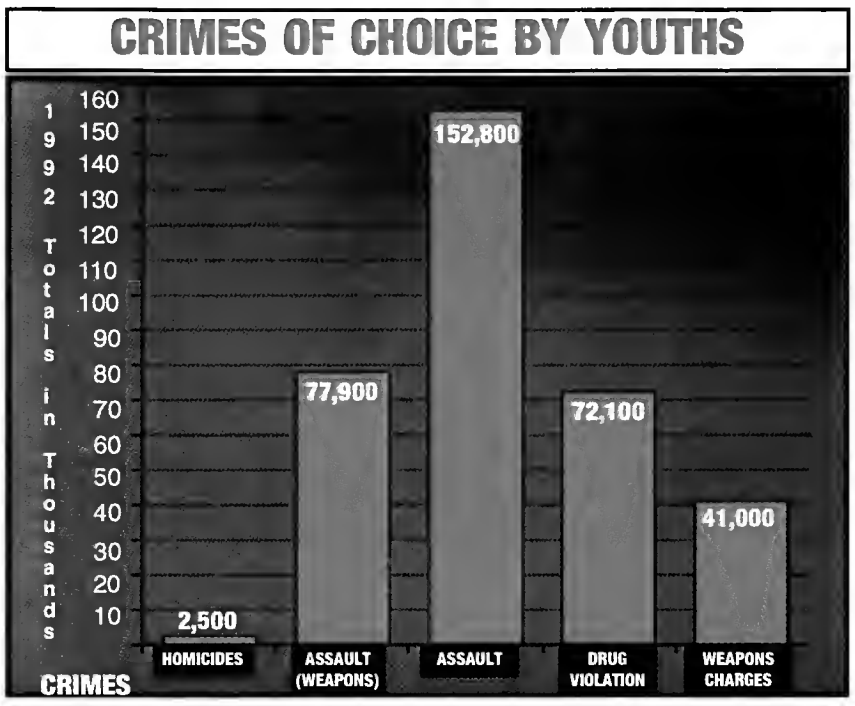
Characteristics of Homicide

The characteristics of homicide are dramatically different than those predominantly portrayed in the media. Eighty percent of the victims are the same race as their assailant. Approximately 55 percent of all homicides occur between acquaintances, 20 percent of them family members; the remaining 45 percent occur between





strangers. Firearms are used in over fifty percent of homicides and alcohol and other drugs have been shown to be an associated factor.[4] Forty-seven percent of all homicides are precipitated by an argument, while only fifteen percent were related to the commission of a felony.



APPROACHES TO VIOLENCE PREVENTION

The elimination of handguns and/or semi-automatic weaponry is an environmental change which could be effective because guns are used in the majority of all homicide. While eliminating the number of guns in the environment may reduce homicide, it would not be expected to cause a significant reduction in the number of injuries related to interpersonal violence.[5] Therefore prevention strategies for interpersonal violence must be developed within the following framework:[6]

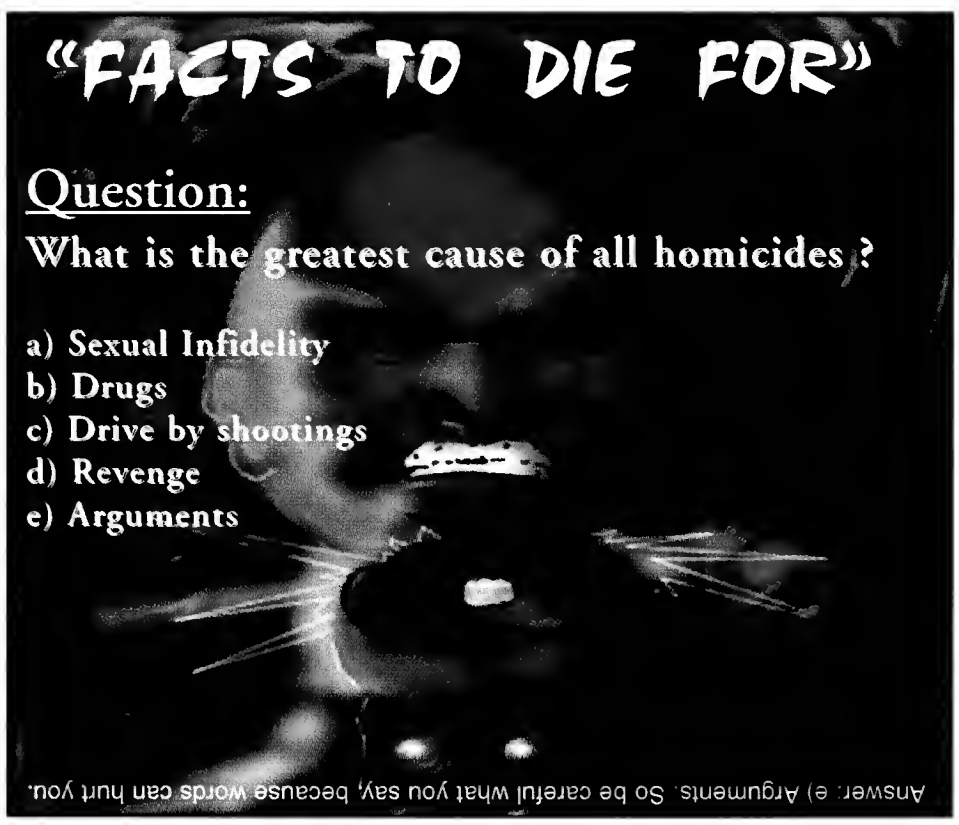
- ◆Although less applicable, the traditional public health model of disease can serve as a super structure for prevention efforts.
- ◆Prevention strategies must focus to a large extent on behavior change.
- ◆Environmental changes are expected to be less effective when applied to intentional injuries.
- ◆Prevention strategies must be designed to increase an individuals threshold for violence, and are applicable to both the potential victim and assailant.

Conflict resolution guides and the use of role play to practice alternatives to violence are behavioral modification strategies which can be successfully utilized in a interpersonal violence prevention effort. Issues such as, defining what is "normal", narcissism/machoism, cowardice, and peer pressure should be addressed when designing an effective violence prevention program. However, any violence prevention effort which is not culturally competent and does not address age specific issues is doomed for failure.

Violence prevention strategies which are effective with urban African American adolescents of lower socioeconomic status requires an understanding of adolescence, issues of race, and poverty. The experience of poverty and racism can significantly hinder the development of essential cognitive and social skills. The development of healthy self-identity requires a sense of self-esteem and a healthy racial identity, both of which can be undermined by poverty and racism. Preparation for future work and responsibility are futile tasks when unemployment rates are prohibitively high. Developing a sense of moral character, functional personal value system or sexual identity is difficult when raised in a single parent environment with television and the street as main sources of knowledge and values. Anger which results from the impact of these socioeconomic factors is normal. The goal therefore of violence prevention is to achieve a healthier response to the anger generated by these and other predisposing factors, not to eliminate the anger itself.

References

1. National Committee for Injury Prevention and Control. Injury Prevention: Meeting the challenge. Oxford University Press as a supplement to the Am J Prev Med 1989;5 (suppl):1-303
2. Barancik, J.I. "Northeastern Ohio Trauma Study: Magnitude of the Problem." American Journal of Public Health, July 1983, Vol 73:7, pp 746-51
3. Centerwall, B. "Race, Socioeconomic Status and Domestic Homicide, Atlanta 1971-72." American Journal of Public Health, 1984 vol 74: 1813-15.
4. Little, J.W. Delinquency Prevention: Selective Organizational Change in the School. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 1981.
5. Hausman, A.J., Spivak H., Prothrow-Stith, D., et. al. "Patterns of Teen Exposure to a Community-Based Violence Prevention Project." Journal of Adolescent Health, 1992; 13: 668-675.
6. Prothrow-Stith, D., Hausman, A.J., Spivak H., , et. al. " The Violence Prevention Project: A Public Health Approach". Science, Tech Human Val 1987; 12: 67-69
7. District of Columbia data taken from: "Indices: A Statistical Index to District of Columbia Services 1992", prepared by the D.C. Office of Policy and Evaluation; and, "The 1991 Crime & Justice Report", prepared by the Criminal Justice Research Center, D.C. Office of Grants Management and Development.



CHECK YOURSELF BEFORE YOU WRECK YOURSELF !

FACT SHEET Produced By The HELIX GROUP Inc. For the SYNERGY ADOLESCENT HEALTH PROJECT: Colevia A. Carter, Project Director, phone# (202) 541-3838
Office of Maternal and Child Health, Commission of Public Health, Department of Human Services. Government of the District of Columbia, Marion Barry, Mayor
Funded By CDC/DASH

(202) 645-5625